CHANGING PATTERNS OF STAFFING

Rural hospitals in the 1990s are faced with mounting pressures related to the growth of managed care, capitation, and other payment arrangements that fix in advance the amount of reimbursement a hospital will receive for a patient's care. As less care is delivered on a fee-for-service basis, hospitals need to ensure that they are providing care as efficiently as possible without sacrificing quality. The shorter hospital stays discussed above are one way in which rural hospitals are working to improve efficiency; recent changes in staffing levels represent another.

Table 8: Rural Hospital Staffing Trends, 1991 and 1994-1995

Full Time Equivalents	1991	1994	1995	% Change 1991-95	% Change 1994-95
Registered Nurses	109,527	124,887	129,511	18.2%	3.7%
Licensed Practical Nurses	41,560	41,006	41,062	-1.2%	0.1%
Physicians (employed)	1,761	3,543	5,194	194.9%	46.6%
Other	374,646	395,018	410,059	9.5%	3.8%
Total	527,494	564,454	585,826	11.1%	3.8%
FTEs per 1,000 Adjusted Admission	69.5	68.7	67.7	-2.6%	-1.5%

Slower declines in admissions accompanied by rapid growth in outpatient visits have meant that rural hospitals have added personnel in the 1990s (table 8). Relative to patient volume, however, the number of full-time equivalent

employees (FTEs) actually decreased between 1991 and 1995. The ratio of FTEs to adjusted admissions (a measure of patient volume that includes both inpatient and outpatient care) declined by 2.6 percent during this period.

Another noteworthy staffing trend at rural hospitals has been the tremendous growth in the number of physicians on hospital payrolls. In 1995, rural hospitals employed 5,194 physicians, almost triple the corresponding 1991 figure. The increase reflects changes in the practice environment for physicians brought on primarily by the spread of managed care. Physicians are finding the administrative demands and discounting for managed care arrangements burdensome. As a result, physicians are increasingly opting for other alternatives, such as group practices or employment by hospitals or health plans.

FINANCIAL TRENDS

Hospital Expenses

By shortening hospital stays, referring patients when appropriate to lower-cost outpatient or long-term settings, and matching staffing levels to patient volume, rural hospitals have been successful in slowing the growth of inpatient costs per case in the past few years (table 9). Cost-per-case growth in both 1994 and 1995, at 1.9 percent and 1.3 percent respectively, was below the rate of inflation in the general economy for those years as measured by the Consumer Price Index (CPI) which rose 2.6 percent in 1994 and 3.0 percent in 1995.

Table 9: Rural Hospital Cost per Case*, by Bed-size 1991-1995

Hospital Bed Size	1991	1992	1993	1994	1995
6 to 49 Beds	$2,921	$3,141	$3,270	$3,344	$3,427
50 to 99 Beds	$3,209	$3,492	$3,628	$3,714	$3,834
100+ Beds	$3,752	$4,091	$4,365	$4,444	$4,492
Total Rural Hospitals	$3,474	$3,782	$3,992	$4,068	$4,121

Percent Change Cost per Case	1991 to 1992	1992 to 1993	1993 to 1994	1994 to 1995
6 to 49 Beds	7.5%	4.1%	2.3%	2.5%
50 to 99 Beds	8.8%	3.9%	2.4%	3.2%
100+ Beds	9.0%	6.7%	1.8%	1.1%
Total Rural Hospitals	8.9%	5.6%	1.9%	1.3%

* Cost per Case is calculated by dividing Total Expenses by Adjusted Admissions.

Growth in total rural hospital expenses also slowed in recent years. Total expenses rose 6.7 percent in 1995, compared with 9.1 percent in both 1992 and 1993 (table 10).

Table 10. Total Rural Hospital Expenses, 1991 to 1995

Year	Total Expenses	% Change
1991	$26,363,516,139	Not Applicable
1992	$28,770,936,194	9.1%
1993	$31,398,442,411	9.1%
1994	$33,419,288,000	6.4%
1995	$35,654,426,534	6.7%

Payer Mix

Rural hospitals are heavily dependent on government sources of revenue, and this dependence has increased since 1991 (table 11). In 1995, government sources, including Medicare, Medicaid, and other public programs, accounted for 53.1 percent of net patient revenues received by rural hospitals. This percentage was up from just over 47 percent three years earlier. Medicare represents the single largest payer of rural hospital services, reflecting the relatively high concentrations of elderly residents in rural areas.

Rural hospitals also serve a high volume of uninsured patients which is reflected in hospitals' uncompensated care burdens. In 1995, the costs of uncompensated care, which includes both bad debt and charity care, amounted to 5.7 percent of rural hospital expenses. This figure was up from 5.3 percent in both 1991 and 1994.

Table 11. Distribution of Net Patient Revenue at Rural Hospitals, 1991 and 1995

Payer Type	1991	1995
Medicare	37.3%	42.1%
Medicaid	9.2%	11.0%
Other Government	0.9%	1.2%
Self Pay	9.0%	6.9%
Third Party	40.0%	35.3%
Other Non-Government	3.4%	3.5%

Revenue Margins

Slower growth in hospital expenses since 1991 has resulted in gains in revenue margins for many rural hospitals. At the aggregate national level, the rural net patient margin, which expresses the extent to which revenues from patient care exceed or fall short of hospital expenses, rose from -0.6 percent in 1991 to 1.0 percent in 1995 (table 12). The aggregate total net margin (which includes contributions, grants, and other revenues not made on behalf of individual patients) also increased, rising from 5.3 percent in 1991 to 6.4 percent in 1995.

Table 12. Aggregate Revenue Margins for Rural Hospitals in 1991 and 1994-1995

Hospital Margin	1991	1994	1995
Total Margin	5.3%	5.4%	6.4%
Patient Margin	-0.6%	0.2%	1.0%

Individual hospital margins indicate however, that many rural hospitals continue to operate at a loss. Patient care revenues fell short of covering expenses at 55.6 percent of rural hospitals in 1995. Even after adding in nonpatient sources of revenue, 23.3 percent of rural hospitals reported deficits in 1995.

SYSTEM, ALLIANCE, AND NETWORK PARTICIPATION

Rural hospitals continue to build relationships with other hospitals, physicians, and other health care providers. For instance, 25.7 percent of rural hospitals

belonged to health care systems[3] in 1995, and 22.8 percent were members of alliances[4] (table 13). Belonging to a system or alliance can provide smaller hospitals with such benefits as access to management and marketing expertise and economies of scale in purchasing. In addition, rural hospitals are increasingly forming health networks[5] as a means of improving the delivery of care in their communities. In 1995, 22.8 percent of rural hospitals participated in health networks, up from 17.6 percent just one year earlier.

Table 13: Rural Hospital System, Alliance, and Network Participation by Bed-size, 1991 and 1994-1995

Rural Hospitals	1991	1994	1995	% Change 1991-95	%Change 1994-95
System Members					
6 to 49 Beds	156	146	161	3.2%	10.3%
50 to 99 Beds	183	193	203	11.1%	5.2%
100+ Beds	190	200	211	11.1%	5.5%
Total System	529	539	575	8.5%	6.7%

[3] A *system* is a corporate body that may own and/or manage health provider facilities or health-related subsidiaries as well as nonhealth-related facilities, including freestanding facilities and/or subsidiary corporations.

[4] An *alliance* is a formal organization, usually owned by shareholders/members, that works on behalf of its individual members in the provision of services and products and the promotion of activities and ventures.

[5] A *network* is a group of hospitals, physicians, other providers, insurers, and/or community agencies that work together to coordinate and deliver a broad spectrum of services to their communities.

Rural Hospitals	1991	1994	1995	% Change 1991-95	%Change 1994-95
System Members					
6 to 49 Beds	156	146	161	3.2%	10.3%
50 to 99 Beds	183	193	203	11.1%	5.2%
100+ Beds	190	200	211	11.1%	5.5%
Total System	529	539	575	8.5%	6.5%
Alliance Member					
6 to 49 Beds	89	144	172	93.3%	19.4%
50 to 99 Beds	105	134	132	25.7%	-1.4%
100+ Beds	185	209	206	11.4%	-1.4%
Total Alliance	379	487	510	35.4%	4.7%
Network Member					
6 to 49 Beds	Not Available	151	206	Not Available	36.4%
50 to 99 Beds	Not Available	122	156	Not Available	27.9%
100+ Beds	Not Available	120	148	Not Available	23.3%
Total Network	Not Available	393	510	Not Available	29.8%

Note: Network participation data were not collected in 1991.

CONCLUSION

From 1991-1995, changes in utilization, staffing and finances have required hospitals to make continued adjustments in the way in which care is delivered. Inpatient use is leveling and outpatient use continues to rise rapidly. Rural hospitals appear to be adapting well to new utilization patterns and the

cost cutting. Networking activities will be of major importance in this environment. Such activities offer a means of ensuring that care is delivered in the most cost-effective setting, that patients have access to a full continuum of health care services, and that care is monitored and managed across settings so that quality problems or disruptions in care can be avoided.

SOURCES

American Hospital Association. *Hospital Stat: Emerging Trends in Hospitals.* 1995-96 edition.

American Hospital Association. *Hospital Statistics.* 1994-95 edition.

Division of Strategic Planning and Marketing of the American Hospital Association. *Environmental Assessment for Rural Hospitals 1992.* Chicago: 1992.

AHA No. 184100

American Hospital Association
One North Franklin Street, Chicago, IL 60606

SUNSHINE PERIOD 96-45

DEPARTMENT OF HEALTH & HUMAN SERVICES
BUREAU OF PRIMARY HEALTH CARE

Public Health Service

Health Resources and Services Administration
Bethesda, MD 20814

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Federal Communications Commission
Office of Secretary

MAR 31 1997

NOTE TO JOHN CLARK

RE: Number of Rural Health Centers

Attached is an urban/rural profile of health centers funded by the Health Resources and Services Administration through Section 330 of the Public Health Service Act. In fiscal year 1995 (same in FY 1996), a total of 389 health center organizations were funded in rural areas. These organizations provided preventive and primary care services to approximately 3.8 million uninsured and underserved people in rural communities.

This information is collected annually from our health centers. If you need any additional information, please contact Jim Macrae of my staff. He can be reached at (301) 594-4319.

Richard C. Bohrer

Richard C. Bohrer
Director
Division of Community and
Migrant Health

Health Center Program Statistics*

FY 1995

	Urban		Rural		Total
Grantee Organizations	333	(46%)	389	(54%)	722
Grant Awards	405	(44%)	508	(56%)	913
People Served	4,313,000	(53%)	3,806,000	(47%)	8,119,000
Service Delivery Sites	1,032	(47%)	1,172	(53%)	2,204
Health Center Grant Funds (millions)	$412.0	(54%)	$344.5	(46%)	$756.5
Other Funds (millions)	$912.4	(52%)	$841.1	(48%)	$1753.5
Total Funds (millions)	$1324.4	(53%)	$1185.6	(47%)	$2510.0

* Includes Community/Migrant Health Centers, Health Care for the Homeless, Health Services for Residents of Public Housing, and Healthy Schools, Healthy Communities Programs

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Bureau of Primary Health Care

Health Resources and Services Administration
Bethesda, MD 20814

DIVISION OF COMMUNITY AND MIGRANT HEALTH
4350 EAST WEST HIGHWAY, 7TH FLOOR
BETHESDA, MARYLAND 20814
FAX #: (301) 594-4997 OR (301) 594-4983

TO: Astrid Carlson

FAX #: ( )

DATE: 3/31/97

FROM: Jim Macrae

PHONE #: (301) 594-4319

OF PAGES INCLUDING COVER: 3

COMMENTS: Here's the info.
Hope it helps!
Jim

SUNSHINE PERIOD

FACSIMILE

To: John Clark

FAX Number: 202 530-0518

Date: September 5, 1996

Subject: Rural Teaching Hospitals

Number of Pages Following this Cover Sheet: 4

AAMC

John -

A list of rural teaching hospitals is attached. The list reports the hospital name (MNAME), city (MLOCCITY), state (MLOCSTCD; a list of the states' codes is also attached, following the list) and zip code (MLOCZIP). I've also attached a list of our definitions of teaching hospitals. Please note that these hospitals are acute care, general, non-Federal institutions.

I hope you find this information useful. Please let me know if you have any questions.

National Center
for Higher Ed.
Bonnie Snedeker
Curriculum Dev.
Education Prog.

From:

Kevin G. Serrin
Research Associate
Association of American Medical Colleges
Division of Health Care Affairs
2450 N Street, N.W.
Washington, DC 20037-1126

Phone: 202 828-0541
FAX: 202 828-4792
internet: kgserrin@aamc.org

```
-> LIST
->   VARIABLES=mname mloccity mlocstcd mloczip
->   /CASES= BY 1
->   /FORMAT=  WRAP  UNNUMBERED .

3,728 bytes of memory required for the LIST procedure.
3,584 bytes have already been acquired.
144 bytes remain to be acquired.
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MNAME	MLOCCITY	MLOCSTCD	MLOCZIP
KENNEBEC VALLEY MEDICAL CENTER	AUGUSTA	11	04330
MID-MAINE MEDICAL CENTER	WATERVILLE	11	04901
WATERVILLE OSTEO HOSPITAL	WATERVILLE	11	04901
CONCORD HOSPITAL	CONCORD	12	03301
MARY HITCHCOCK MEM HOSPITAL	LEBANON	12	03756
MARY IMOGENE BASSETT HOSPITAL	COOPERSTOWN	21	13326
OLEAN GENERAL HOSPITAL	OLEAN	21	14760
NATHAN LITTAUER HOSPITAL	GLOVERSVILLE	21	12078
BENEDICTINE HOSPITAL	KINGSTON	21	12401
KINGSTON HOSPITAL	KINGSTON	21	12401
CHAMPLAIN VLY PHYS HSP MED CTR	PLATTSBURGH	21	12901
CLEARFIELD HOSPITAL	CLEARFIELD	23	16830
GEISINGER MEDICAL CENTER	DANVILLE	23	17822
GOOD SAMARITAN REG MED CENTER	POTTSVILLE	23	17901
ROBERT PACKER HOSPITAL	SAYRE	23	18840
WAYNESBORO HOSPITAL	WAYNESBORO	23	17268
CLARION HOSPITAL	CLARION	23	16214
ALLEGHANY REGIONAL HOSPITAL	LOW MOOR	34	24457
NORTHAMPTON-ACCOMACK MEM HOSP	NASSAWADOX	34	23413
UNITED HOSPITAL CENTER	CLARKSBURG	35	26301
LOGAN GENERAL HOSPITAL	LOGAN	35	25601
MONONGALIA GENERAL HOSPITAL	MORGANTOWN	35	26505
WEST VIRGINIA UNIV HOSPITALS	MORGANTOWN	35	26506
ROANOKE-CHOWAN HOSPITAL	AHOSKIE	36	27910
MARTIN GENERAL HOSPITAL	WILLIAMSTON	36	27892
SELF MEMORIAL HOSPITAL	GREENWOOD	37	29646
FAIRFIELD MEMORIAL HOSPITAL	WINNSBORO	37	29180
FLOYD MEDICAL CENTER	ROME	38	30165
FIRELANDS COMMUNITY HOSPITAL	SANDUSKY	41	44870
O'BLENESS MEMORIAL HOSPITAL	ATHENS	41	45701
MARY RUTAN HOSPITAL	BELLEFONTAINE	41	43311
MEDICAL CENTER HOSPITAL	CHILLICOTHE	41	45601
HOLZER MEDICAL CENTER	GALLIPOLIS	41	45631
KNOX COMMUNITY HOSPITAL	MOUNT VERNON	41	43050
WYANDOT MEMORIAL HOSPITAL	UPPER SANDUSKY	41	43351
FAYETTE COUNTY MEM HOSPITAL	WASHINGTON CT HOUSE	41	43160
BETHESDA HOSPITAL	ZANESVILLE	41	43701
GOOD SAMARITAN MEDICAL CENTER	ZANESVILLE	41	43701
BLESSING HOSPITAL	QUINCY	43	62301
MEMORIAL HOSP OF CARBONDALE	CARBONDALE	43	62902
CARSON CITY HOSPITAL	CARSON CITY	44	48811
COMM HLTH CTR OF BRANCH CNTY	COLDWATER	44	49036
MARQUETTE GENERAL HOSPITAL	MARQUETTE	44	49855
NORTHERN MICHIGAN HOSPITAL	PETOSKEY	44	49770
ST JOSEPH'S HOSPITAL	MARSHFIELD	45	54449
EPHRAIM MCDOWELL REG MED CTR	DANVILLE	51	40422
ARH REGIONAL MEDICAL CENTER	HAZARD	51	41701
REG MED CTR OF HOPKINS CNTY	MADISONVILLE	51	42431
ST CLAIRE MEDICAL CENTER	MOREHEAD	51	40351
HIGHLANDS REGIONAL MED CENTER	PRESTONSBURG	51	41653
VAUGHAN REGIONAL MEDICAL CTR	SELMA	53	36701
NORTH MISSISSIPPI MED CENTER	TUPELO	54	38801
ST FRANCIS MEDICAL CENTER	BRECKENRIDGE	61	56520
NORTH IOWA MERCY HLTH CTR	MASON CITY	62	50401
CAPITAL REGION MEDICAL CTR	JEFFERSON CITY	63	65101
PHELPS CNTY REGIONAL MED CNTR	ROLLA	63	65401
ST ANDREW'S HEALTH CENTER	BOTTINEAU	64	58318
ST LUKE'S TRI-STATE HOSPITAL	BOWMAN	64	58623
TOWNER COUNTY MEM HOSPITAL	CANDO	64	58324
CARRINGTON HEALTH CENTER	CARRINGTON	64	58421
PEMBINA CNTY MEM HOSPITAL	CAVALIER	64	58220
MERCY HOSPITAL	DEVILS LAKE	64	58301
ST JOSEPH'S HOSP & HEALTH CTR	DICKINSON	64	58601
UNITY MEDICAL CENTER	GRAFTON	64	58237

SAKAKAWEA MEDICAL CENTER	HAZEN	64	58545
WEST RIVER REGIONAL MED CTR	HETTINGER	64	58639
JAMESTOWN HOSPITAL	JAMESTOWN	64	58401
HILLSBORO COMMUNITY HOSPITAL	HILLSBORO	64	58045
UNIMED MEDICAL CENTER	MINOT	64	58702
CAVALIER COUNTY MEM HOSPITAL	LANGDON	64	58249
LINTON HOSPITAL	LINTON	64	58552
COMMUNITY MEMORIAL HOSPITAL	LISBON	64	58054
UNION HOSPITAL	MAYVILLE	64	58257
TRINITY MEDICAL CENTER	MINOT	64	58701
PRESENTATION MEDICAL CENTER	ROLLA	64	58367
HEART OF AMERICA MEDICAL CNTR	RUGBY	64	58368
TIOGA MEDICAL CENTER	TIOGA	64	58852
MERCY HOSPITAL	VALLEY CITY	64	58072
WISHEK COMMUNITY HOSPITAL	WISHEK	64	58495
BROOKINGS HOSPITAL	BROOKINGS	65	57006
PRAIRIE LAKES HOSPITAL	WATERTOWN	65	57201
SACRED HEART HEALTH SERVICES	YANKTON	65	57078
GOOD SAMARITAN HEALTH SYSTEMS	KEARNEY	66	68847
SAINT FRANCIS MEDICAL CENTER	GRAND ISLAND	66	68803
ASBURY-SALINA REG MEDICAL CTR	SALINA	67	67401
ST JOHN'S REGIONAL HEALTH CTR	SALINA	67	67401
MEDICAL CTR OF SOUTH ARKANSAS	EL DORADO	71	71730
ST BERNARDS REGIONAL MED CTR	JONESBORO	71	72401
JANE PHILLIPS MEDICAL CENTER	BARTLESVILLE	73	74006
BANNOCK REGIONAL MEDICAL CTR	POCATELLO	82	83201
POCATELLO REG MEDICAL CENTER	POCATELLO	82	83201
VAIL VALLEY MEDICAL CENTER	VAIL	84	81657
WRAY COMMUNITY DIST HOSPITAL	WRAY	84	80758
ST CHARLES MEDICAL CENTER	BEND	92	97701
MERLE WEST MEDICAL CENTER	KLAMATH FALLS	92	97601
JOHN C FREMONT HEALTHCARE	MARIPOSA	93	95338

Number of cases read: 98 Number of cases listed: 98

Preceding task required 6.15 seconds elapsed.

1994 ANNUAL SURVEY OF HOSPITALS

STATE AND REGION CODES

REGION 1
(NEW ENGLAND)

11 MAINE
12 NEW HAMPSHIRE
13 VERMONT
14 MASSACHUSETTS
15 RHODE ISLAND
16 CONNECTICUT

REGION 2
(MID ATLANTIC)

21 NEW YORK
22 NEW JERSEY
23 PENNSYLVANIA

REGION 3
(SOUTH ATLANTIC)

31 DELAWARE
32 MARYLAND
33 DIST. OF COLUMBIA
34 VIRGINIA
35 WEST VIRGINIA
36 NORTH CAROLINA
37 SOUTH CAROLINA
38 GEORGIA
39 FLORIDA

REGION 4
(EAST NORTH CENTRAL)

41 OHIO
42 INDIANA
43 ILLINOIS
44 MICHIGAN
45 WISCONSIN

REGION 5
(EAST SOUTH CENTRAL)

51 KENTUCKY
52 TENNESSEE
53 ALABAMA
54 MISSISSIPPI

REGION 6
(WEST NORTH CENTRAL)

61 MINNESOTA
62 IOWA
63 MISSOURI
64 NORTH DAKOTA
65 SOUTH DAKOTA
66 NEBRASKA
67 KANSAS

REGION 7
(WEST SOUTH CENTRAL)

71 ARKANSAS
72 LOUISIANA
73 OKLAHOMA
74 TEXAS

REGION 8
(MOUNTAIN)

81 MONTANA
82 IDAHO
83 WYOMING
84 COLORADO
85 NEW MEXICO
86 ARIZONA
87 UTAH
88 NEVADA

REGION 9
(PACIFIC)

91 WASHINGTON
92 OREGON
93 CALIFORNIA
94 ALASKA
95 HAWAII

REGION 0
(ASSOCIATED AREAS)

03 MARSHALL ISLANDS
04 PUERTO RICO
05 VIRGIN ISLANDS
06 GUAM
07 AMERICAN SAMOA

G. NOTE CONCERNING TEACHING HOSPITALS

The AAMC Division of Health Care Affairs, which houses the Council of Teaching Hospitals and Health Systems (COTH), Group on Faculty Practice and the Section for Resident Education, provides policy analysis on graduate medical education financing and other hospital and physician issues. The data in this Section include the findings from the COTH Survey of Housestaff Stipends, Benefits, and Funding and the American Hospital Association (AHA) Annual Survey of Hospitals as analyzed by the AAMC Division of Health Care Affairs.

For purposes of the tables in this section, a hospital is considered a teaching hospital if it meets at least one of the following criteria:

- a medical school affiliation reported to the American Medical Association;
- a residency program accredited by the Accreditation Council of Graduate Medical Education;
- an internship approved by the American Osteopathic Association (AOA); or
- a residency approved by the AOA.

All members of the COTH are considered academic medical center (AMC) hospitals. There are three categories of AMC hospitals:

Integrated. Integrated AMC hospital refers to a short-stay, general service, non-federal hospital which has a signed affiliation agreement with a college of medicine accredited by the Liaison Committee on Medical Education (LCME). The hospital must be under common ownership with a college of medicine **or** have the majority of medical school department chairmen serve as the hospital chiefs of service, **or** have the chairman responsible for appointing the hospital chief of service.

Independent. Independent AMC hospital refers to a short-stay, general service, non-federal hospital which has a signed affiliation agreement with a LCME accredited college of medicine and sponsors or significantly participates in graduate medical education.

VA/Children's/Specialty. VA/Children's/Specialty AMC hospital refers to a federal or non-federal hospital that is **not** a short-stay, general service hospital, but has a documented affiliation agreement with a college of medicine accredited by the LCME.

Questions regarding the AAMC data for Housestaff Stipends, Benefits and Funding should be directed to Ingrid Philibert, Staff Associate, Division of Health Care Affairs, at (202) 828-0497. Questions regarding hospital operational and financial data should be directed to Kevin Serrin, Research Associate, Division of Health Care Affairs, at (202) 828-0541.

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96-45

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From: root@acuta.org[SMTP:root@acuta.org]
Sent: Wednesday, April 23, 1997 8:31 AM
To: member@acuta.org
Subject: ACUTA Regulatory Alert

ACUTA Regulatory Alert

FCC Access Charge Reform Could Result in Dramatic Cost Increases for Business Telephone Customers

ACUTA members should be aware of two issues currently before the Federal Communications Commission (FCC) that could significantly increase the telecommunications costs of higher education institutions and other large multi-line business users. These proposals pertain to changes in universal service and interstate access charge rules.

A decision may be made on these proposals by May 6. Although it has not been announced publicly, ACUTA has learned that the leadership of the FCC is reportedly considering proposals that would target multi-line business customers with major increases in the Subscriber Line Charges (SLC), in order to generate nearly $3 billion in additional revenue. This revenue would be used to subsidize inside wiring and access to the network for public K-12 schools and libraries, access to the network for rural health care facilities, and increases in lifeline service.

The Telecommunications Act of 1996 requires the FCC to establish rules for discounted telecom services for K-12 schools, libraries, and rural health facilities, subsidized through the Universal Service Fund. However, wiring is not called for in this legislation.

Under the proposal being promoted by the Chairman of the FCC, the following increases could occur:

* The cap on business multi-line Subscriber Line Charges (SLC) may be raised from $6 per line to $9.50 per line per month, including Centrex lines.

* A pre-subscribed line (PSL) surcharge will be imposed on business users. The charge is anticipated at $4.50 per multi-line business line. The $4.50 per month charge would also apply to each Centrex line.

* The SLC cap on second residential lines may be raised from $3.50 to $6.00 per month. This will affect university employees and students who telecommute.

* Cellular, PCS, and paging customers may be assessed a $1.00 per telephone number per month "universal service social agenda obligation" fee.

According to the information ACUTA has received, it appears from our initial analysis that a university that has 10,000 Centrex lines would

be affected as follows: $3.50 per month potential increase in SLC, $4.50 per month new PSL totaling $8.00 per line in additional fees, or $80,000 in additional charges per month. It is important to note that these are estimates, and the actual effect may vary.

Interstate access charges are also planned to be cut 40 - 50% in the first year, resulting in lost access charge revenue. The net effect of these changes will be dramatic cost increases for business users, including higher education institutions. Various members of the ACUTA Legislative/Regulatory Affairs Committee have estimated that their individual university could suffer a combination of cost increases and lost revenue ranging between $43,000 and $250,000 per year.

If your university is concerned about this potential huge cost increase, we urge you to work with your institution's leadership and governmental relations departments immediately to express your opposition. Time is of the essence. Correspondence may be addressed to the each of the following FCC Commissioners, and should be faxed to them as soon as possible. It is important to write to all of the commissioners, not just the Chairman. Their names and fax numbers are as follows:

Chairman Reed E. Hundt Fax 202-418-2801
Commissioner James E. Quello Fax 202-418-2802
Commissioner Rachelle B. Chong Fax 202-418-2820
Commissioner Susan Ness Fax 202-418-2821

Mailing Address for the Commissioners:
Federal Communications Commission
1919 M Street, NW
Washington, DC 20554

Please note at the top of each letter: "Ex Parte Communication in CC Docket No. 96-262". Please copy all letters to attorney Brian Moir, at Fax# 202-331-9854. Also copy the letter to Jeri Semer at the ACUTA office, Fax#606-278-3268.

In addition, we suggest you consider copying this letter to your state's two Senators and the Member of Congress from your school's district. The Congress should be made aware of the FCC's plan to target business users disproportionately in an effort to achieve the universal service social agenda.

More information on Universal Service and Access Charge Reform is available from the FCC Web site, www.fcc.gov. You can reach the FCC Web site through the ACUTA Web site, www.acuta.org, through a link from the Legislative/Regulatory section.

Jeri A. Semer
Executive Director
Association of College and University
Telecommunications Administrators (ACUTA)
152 W. Zandale Dr., Suite 200
Lexington, KY 40503
Phone: (606)278-3338
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E-Mail: jsemer@acuta.org
World Wide Web: http://www.acuta.org

Trish -

① Please FAX orig. & cc today. All FAX numbers should be noted below.

② Also please cc Gorman & Oberdorfer & T-Hoeve & Brat.

Steve

FILE=REW
JANNEY MONTGOMERY SCOTT INC.
MORNING MEETING SUMMARY
MAY 6, 1997

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617-227-1514

Telecom Industry Update: Access Charges and Universal Service

As we wrote in our note yesterday, we expect an access cut in the $1.5-$2.0 range on July 1st. $1.7 billion is the number currently being discussed, and it is the amount AT&T has promised the IXCs would pass through in rate cuts. That $1.7 billion comes from two sources. Price-cap reductions would contribute $1.4 billion, as a result of a higher productivity factor, probably 6.5% and probably retroactive to 1996, and some disallowances. About another $300 million would result from increases in Subscriber Line Charges (SLC) on multiline businesses. That entire amount is available for the IXCs to use for rate cuts, since there is no offsetting new Universal Service obligation till January.

In January, the Universal Service Fund for schools and libraries should begin to phase in. We expect the ultimate total to be $2.25 billion, but a gradual phase-in is likely. The 1997 amount may well be in the $1.2-$1.5 billion range. Assuming funding is based on retail interstate and intrastate revenues, we expect just under 40% of the amount to be funded by the IXCs, just about 20% by new participants like wireless carriers, operator services, and CLECs, and just over 40% by the LECs. It is important to note, however, that the LECs= contribution becomes a new expense factor in the price-cap formula, which enables most of it to be passed through in access charges. Specifically, 85% of the LECs= contribution can be passed through as a new revenue requirement in price caps, and, thus, ultimately it winds up being funded by the IXCs. Thus, if the Fund in 1997 were $1.5 billion, the IXCs would pay just under $600 million directly and roughly another $500 million through Aaccess flowback,@ for a total of $1.1 billion.

Helping the IXCs would be the second phase of SLC increases, which are revenues that come in to the LECs from end users and result in a lower access revenue requirement to be funded by the IXCs. Thus, the education Fund will pass through the price-cap formula as an increased revenue requirement and the SLC raise as a decreased revenue requirement. The January portion of the SLC increase should amount to about $500 million, offsetting the Aaccess flowback.@ The IXCs would also be helped by a reduction in their contribution to current high-cost support. LECs and new carriers will take over part of the obligation the IXCs carry alone today, saving the IXCs about $300 million. Thus, if the education Fund is $1.5 billion for 1997, the IXCs= net new burden would be $300 million: $1.1billion in direct and access flowback contributions, minus $500 million in SLC benefits, minus $300 million in high-cost reduction. If it is the full $2.25 billion, the IXCs would fund about $850 million directly, about another $850 million through access flowback, and would still only see $500 million in SLC benefits and $300 million in high-cost reductions. Their net burden then would become about $900 million.

Also on January 1, 1998, we expect the new PICC charge to begin. This flat-rate charge is paid by the IXCs to the LECs for all their presubscribed lines. In return, the LECs will lower their per minute charges by an equivalent amount, minus their new net burden for Universal Service . We expect the PICC to amount to about $2.5 billion in total new charges. That assumes the largest component, the $4.50 per-month per-line charge on businesses is not reduced or phased in gradually. Given the opposition of some businesses to the increase in flat rates and the discomfort Commissioner Chong has voiced, a gradual phase-in is a real possibility. Her concern is that small businesses that make few long distance calls and, therefore, will see little in the way of per-minute savings, will wind up with larger phone bills as a result of the increased per-line rates. Various options have been suggested, ranging from a gradual phase-in, to a $2 cap instead of a $4.50 cap, to a $2 cap for businesses with a small number of lines, e.g. fewer than 10. The $2.5 billion total in new flat-rate charges also assumes the residential charge remains at its current level of about $.50 on primary lines and rises to $1.50 on secondary lines.

We would expect AT&T to reduce its per minute rates to its customers to the extent that it can pass through the new flat rates, minus its residual contribution to the education Fund. Assuming a pass through of $1.25 billion or 50% of the PICC in flat rates, and assuming a $300 million net burden, the IXCs could pass through just under $1 billion in per minute long distance rates, beyond the cuts that result from price-cap decreases. If they manage 100% PICC pass through, the IXCs would be able to lower per minute rates by an additional $2.2 billion. Including the July reduction of $1.7 billion, per minute rates would fall by at most about $4 billion. That is about one third of switched access charges, and would bring the access rate to about 1.8 cents on each end of a call from 2.7 cents. Counting both ends of each call, that would result in a 1.8 cent or 12% reduction in long-distance rates per minute, given that average revenue per minute is 15 cents. Were the IXCs able to pass through only 50% of the flat rate, the reduction would be $1.2 billion less, bringing access down by only about 0.6 cents at each end of a call, and bringing long-distance rates down by 8% on average. Finally, were the full education Fund implemented January 1st, with a net IXC burden of about $900 million dollars instead of $300 million, long distance rates could fall only by only about 1 cent per minute or 6%.

The net cost to the LECs as a group is likely to be $1.4 billion in price-cap cuts beginning July 1997. We expect the LECs' contribution to the education Fund to essentially net out with the added revenues from SLC increases, as long as the Fund in 1998 is only $1.5 billion. Even if the full Fund were implemented, their exposure would only be very small, because it would be 15% of any amount above the SLC increase. The rest becomes access flowback to the IXCs. The LECs will have a new obligation to the current high-cost Fund, but we expect that to be only in the $200-$300 million range. The flat rating of some per-minute access charges should be revenue neutral, though there is a slight negative future impact from basing access revenue growth on slow-growing lines instead of rapidly-growing minutes. The incentive to bypass LECs also changes. As per-minute rates fall, it becomes somewhat less tempting for carriers to move traffic from switched to dedicated access. On the other hand, for multi-line business end-users, there may be an incentive to move to an alternate local carrier, especially to give the entire account to an IXC, if they can avoid the higher SLC and PICC by doing that, but still enjoy the new, lower long-distance rates.

For CLECs, the access order is likely to be a mixed bag. The cut in per-minute access charges as a whole, and the incentive to move business accounts to IXCs, is not favorable to the CLECs. However, some of the TIC (transport interconnect charge) is being moved into LEC tandem-transport rates. Thus, CLECs will have a higher price umbrella over their trunking and tandem switching business, even while the overall price umbrella on switched access is being lowered. The order is probably also easier on those carriers who can offer a full product line than those whose primary business is access bypass. Having said that, we expect most CLECs to go through a period of adjustment, as they reconfigure their business to make up for disappearing opportunities and take advantage of new ones.

It is much more difficult to predict what the picture will look like past January. Because of the higher productivity factor, one would expect that there will be another large price cap reduction next July, though probably not quite as large as this summer's $1.4 billion. However, over the course of this summer and fall, the FCC will have several proceedings that could impact access charges. They will be looking at the right of the LECs to recover their embedded cost, at pricing flexibility, and at separations. All of these, especially the embedded cost issue, have serious implications for access charges as well as for universal service. The new rural/high cost Fund will also be designed over the next year, and will probably begin to phase in by next summer. Depending on its design, that Fund could create substantial transfers from IXCs to LECs, from low-cost LECs to high-cost LECs, and from CLECs to high-cost LECs. Presumably, but not necessarily, the transfers between LECs would flow through the price-cap formula in a way that is revenue neutral for the IXCs. In other words, the contributing LECs would develop a higher revenue requirement but the LECs that are net gainers from the high-cost Fund would have a lower revenue requirement in their price-cap calculation. To the extent that the IXCs contribute directly to the high-cost Fund, that also would create a lower price-cap revenue requirement for those LECs who are net gainers from the Fund. Assuming the IXCs= Fund contribution is fully offset by lower access charges, the IXCs should be in a position again next July

to provide a rate cut based on productivity-based access reductions. Pressure from actual or impending Regional Bell long-distance entry is likely to reinforce the likelihood of a cut. However, with so many important proceedings ahead, and with three new Commissioners likely to come on board by this summer, the picture is very blurred, indeed.

Key variables in the upcoming order:

The size of the price-cap reduction will translate most directly into access cuts and long distance rate cuts. The bigger it is, the worse for the LECs, CAPs (competitive access providers), and the better for the IXCs, who benefit from stimulation as they lower their rates.

The size of the SLC increase, which is paid by end users and is a net gain to the IXCs, is also critical to the IXCs. It is revenue-neutral to the LECs. The larger the SLC increase, the more per-minute access charges can drop without hurting the LECS and the more long-distance rates can drop without hurting the IXCs.

The PICC charge is also important, although it is revenue neutral to the IXCs, LECs, and end-users in total. It converts some per-minute access rates into flat monthly rates and can, at least in part, result in lower per-minute long-distance rates. That, in turn, should stimulate growth of long-distance traffic.

The size of the education Fund is critical to the IXCs, wireless carriers, CLECs and others who wind up paying for it. It is least important to the LECs, assuming they can pass its cost through to the IXCs via access charges, that is, assuming the price-cap formula is not modified to prevent the LECs from passing it through as an exogenous cost factor. It is, thus, also critical to see whether the FCC modifies the price-cap formula to prevent most Universal Service obligations from ultimately falling back unto the IXCs.

We are maintaining our HOLD ratings on AT&T#, MCI*, and the Regional Bells.

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April 15, 1997

SUNSHINE PERIOD

Honorable James Quello, Commissioner
Federal Communications Commission
1919 M Street, NW - Room 844
Washington, DC 20544

Dear Mr. Quello:

We are writing in strong support of the meaningful discounts for libraries and schools as envisioned by the Federal-State Joint Board in their Recommended Rules published in November, 1996.

The Recommended Rules allow libraries and schools significant discounts for telecommunications and critical non-telecommunications services necessary to assure that all of our public libraries and schools are connected to the Internet and other on-line resources that are critical to live, learn and work in an increasingly information-driven world.

Congress passed the Telecommunications Act of 1996 with the clear intent of insuring that libraries and schools would be able to access the latest technology. By allowing significant discounts on telecommunications services, local wiring and Internet access, the Joint Board has accurately recognized the needs of poorer schools and libraries that cannot afford the internal wiring necessary to connect with the Internet. By allowing telecommunications companies and non-telco carriers to compete for the discounts, the Joint Board has also recognized the need for diverse technologies to serve the diverse urban and rural areas of the State.

We in Illinois are fortunate to have strong support for such a discount. On April 10, the Illinois House approved HB 707 (Telecom Bill) with a 115-0 vote, thus making public libraries and library systems eligible for the same discounted telecommunication rates afforded to other educational institutions included in the Public Utilities Act.

We in Shorewood have strong support from the Shorewood Area Chamber of Commerce for Internet access. However, the monetary portion of the commitment is dependent upon the success of their annual 4-day festival, which in turn, is dependent upon the weather.

Thank you for your attention to this important matter for our libraries and schools -- and -- ultimately for us all, as a better educated community benefits everyone. Please do not hesitate to call if we can be of any further assistance.

Sincerely,

Mary F. Thomas

Mary F. Thomas,
Director
The Staff and Board of Trustees

MFT:sg